

2. indicate priority areas for improvement. Our overarching objective was to provide information to guide policymakers and those tasked with the delivery of graduate medical education in tackling the provision of high-quality clinical learning environments in challenging time

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### Getting a Handle on Handover: Improving the E-Handover Process for Duty Doctors in Psychiatry

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**Aims.** Effective handover is a vital aspect of patient safety and continuity of care. On-call junior doctors (the Duty Doctor) in psychiatry inpatient wards in University Hospital Hairmyres (UHH) and University Hospital Wishaw (UHW) use an electronic handover tool (e-handover) to supplement handover. This lists outstanding jobs and information to be aware of. This project aimed to improve the handover process by making amendments to the e-handover.

**Methods.** A Plan, Do, See, Act (PDSA) cycle structured the project. An electronic survey was sent to all 30 Duty Doctors. This contained a Likert scale, 1 being negative and 10 being positive, to rate the handover process, alongside space for free text comments to be given. Thematic analysis identified common themes within these comments.

Changes were implemented in response to the survey findings. Space was added to the e-handover for each patient's care team (parent team), as well as their contact details. The Duty Doctors were informed of the changes and a post-intervention survey was sent six weeks later.

**Results.** There was a total of 22 responses (73.3%) to the pre-intervention survey. Themes identified from the free text comments included: Organisation of tasks; Ease of use; Reliability; Inappropriate use; Technical issues; Handover update; Task information and Ward information. The most common theme was inappropriate use of e-handover. It was identified that tasks were being added to the e-handover that would be more appropriately actioned by the parent team.

There was a total of 12 responses (40%) to the post-intervention survey. A demonstrable improvement in the rating of the handover process was found. Free text comments showed that the changes made were helpful. Common themes were identified from the comments. One theme was 'Missing information', which included a lack of clarity on the date a job was added to the e-handover. Future changes could include adding space to the e-handover for this information.

**Conclusion.** Following the adjustments made to the e-handover there was an improvement in the satisfaction amongst the Duty Doctors.

One limitation identified was the lower response rate for the post intervention survey. We postulated that this was due to the survey being distributed when junior doctors changed clinical rotations and left the Duty Doctor role. This could be considered for future improvement cycles.

Additionally, free text comments from the post intervention survey could be utilised to inform future improvements.

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### Assessment of Cardiovascular Disease Risk in Adults With Severe Mental Illness Admitted to Acute Psychiatric Unit Using QRISK-3 Assessment Tool: A Quality Improvement Project

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**Aims.** The purpose of this QI project was to assess risk of CVD (cardiovascular disease) in adults with SMI (severe mental illness) admitted to acute psychiatric ward as risk can be reduced by relevant changes in lifestyle, optimizing treatment of relevant comorbidities, and by drug treatment, if appropriate. Nice guidelines for CVD risk assessment and management were followed for those with CVD risk of 10% or more.

**Methods.** This QI project focused on patients with a diagnosis of severe mental illness admitted to ward Ty Cyfannol, YYF hospital, ABUHB in South Wales from 1st April 2021 to 30th November 2021. QRISK<sup>®</sup>3-2018 risk calculator used to estimate risk of cardiovascular disease. Patients younger than 25 years old at the time of QI project were excluded as QRISK tool is only valid for patients aged 25–84 years. Patients who already had a diagnosis of Ischaemic heart disease or stroke/transient ischaemic attack were also excluded as per criteria of QRISK3. Total number of patients included in this project was 43 patients. Data were collected from patients' medical records including their weights, heights, routine physical examinations and laboratory investigations requested during their admission. In order to maintain anonymity, patients were assigned to their hospital number. This information was saved in a password protected Excel Spreadsheet.

**Results.** The mean age of patients was 43.3 ± 11.06 years ranging from 25–69 years. Most patients were males (65.1 %). Schizophrenia was the most prevalent diagnosis (32.5%) followed by emotionally unstable personality disorder (18.6%). 72% out of total 43 patients were smokers. The mean BMI was 23.6 ranging from 17 to 31. 41.9% had their BMI ≥ 25, 8 patients out of those with BMI equal to or higher than 25 scored 10 or more on QRISK3. 13 (30.2%) patients were estimated to have high CVD risk using QRISK3 assessment tool, of whom 76.7% (n=10) aged 55 years or more. 69.2% (n=9) were current smokers, 23% (n=3) were diabetic and 15.2% (n=2) had hypertension.

**Conclusion.** The findings of this project conform the consensus that people with SMI are at a higher risk of having CVD. Therefore, this should emphasize the importance to assess CVD risk in patients with SMI and to manage modifiable risk factors accordingly and to incorporate the assessment of cardiovascular risk in patients with severe mental illness in day-to-day practice in mental health inpatient units.

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